WALKER ROAD CHIROPRACTIC
Chiropractic, Rehab & Massage

Welcome!

Personal Information

Patient Name: _____

Address: _____

City/State/Zip: _____

Employer name: _____

Occupation:_____

Birth date: ____ /____ /____ **Age**:_____ **Gender**:_____

(If 65 years or older please also fill out the Medicare Questionnaire)

Marital Status: _____ **Spouse's Name:** _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Emergency Contact: _____

Emergency Phone Number: _____

Would you like to receive automated text message or email reminders for your appointments? □ Yes □ No

Cell phone carrier for text reminders: _____

Whom may we thank for referring you to us?

□ Patient/Friend/Family _____

□ Physician/Specialist □ Office Event /Health Fair

□ Office Sign/Banner □ Website/Other Advertisement

□ Other: _____

I certify that the information I have completed above is accurate and true to the best of my knowledge.

X _____ _____
Patient's Signature *Date*

Acknowledgement & Agreement

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that pain syndromes can be caused by conditions (such as tumors, etc.), which may be visualized by x-rays. Should the doctor deem x-rays are not necessary for my condition, I agree not to hold anyone associated with this clinic responsible for such pathology. I authorize the release of any medical information necessary to process this claim.

X _____ _____
Patient's Signature *Date*

Accident Information

Is condition due to an accident? **Y N** Date: ____ /____ /____

Type of accident: □ **Auto** □ **Work** □ **Home** □ **Other**

To whom have you made a report of your accident?

□ **Auto** □ **Insurance** □ **Employer** □ **Work Comp** □ **Other**

Notice of Privacy Practices (HIPPA)

I understand and have been provided with a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:
- The right to review the notice prior to signing this consent
- The right to object to use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

X _____ _____
Patient's Signature *Date*

Assignment and Release

I certify that I have insurance coverage with: _____
Name of Insurance Company(ies)
and assign directly to **Walker Road Chiropractic, PC.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Walker Road Chiropractic, PC. may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when I submit written notice to Walker Road Chiropractic, PC.

X _____ _____
Patient's Signature *Date*

Photo ID

Due to the increased cases of identity theft our office will require a copy of your photo ID to verify your identity

Walker Road Chiropractic, PC.
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